UMWA Health and Retirement Funds P.O. Box 99002 Lubbock, TX 79490-9002	Medical Justification Durable Medical Equipment and Respiratory Equipment

PATIENT INFORMATION

Patient Name	HSID #	Date of Birth	Patient Height
Address	Telephone #		Patient Weight

ATTENDING PHYSICIAN INFORMATION

Physician's Name	UMWA Funds Provider #	NPI #
Address	Telephone #	

If this patient has been referred to a specific supplier, please give supplier information, if available.

Name of Supplier	UMWA Funds Provider #
Address	Telephone #

THIS PORTION TO BE COMPLETED BY PATIENT'S ATTENDING PHYSICIAN OR PHYSICIAN'S STAFF

1. Please indicate the following regarding the status of this patient:
   Is the patient ambulatory? ☐ No
   ☐ Yes (If "yes", to what extent?) _____

   Describe the patient's mental status (e.g., coherent and lucid, occasionally disoriented, confused) _____

   The patient can complete self-help tasks: ☐ Independently ☐ With assistance ☐Not at all (is totally dependent)

   Indicate any functional limitations which would have a bearing upon the need for or utilization of the prescribed equipment:

2. Diagnoses that justify the need for equipment/services: _____
3. Prognosis: _____
4. Prescription (equipment or treatment modality): _____

   Reasons for supporting need for the particular equipment prescribed (attach letter, if necessary): _____
5. Location of Pain _____

   Duration of time patient has had pain _____
6. Medication or modalities, such as, therapies that have been tried and whether or not they were successful
7. a. Prescription Date: _____ New Rx: ☐Yes☐ No Recertification: ☐ Yes ☐ No

   b. Equipment need for _____ months duration from _____ to _____
8. Date patient was last examined by you: _____
9. For oxygen equipment, include: Frequency: _____ Flow Rate _____

   Intended method of delivery (mask, nasal cannula, etc.):_____

ABG Test Results*		Spirometric Test Results**	
Date of Testing	Facility/Services Rendered	Date of Testing	Facility/Services Rendered

ABG Performed (Must be checked as appropriate): ☐ At Rest ☐ Room Air ☐Exercise ☐ On Oxygen Rate _____

* Required for all oxygen equipment. A copy of the laboratory results must be attached. If not tested, please explain. Attach letter, if necessary.

** A pre- and post-bronchodilation PFT is required for all Nebulizers, Compressors. A copy of either flow volume loop or time graph must be attached. If not tested, please explain. Attach letter, if necessary.

_____ _____

Attending Physician's Original Signature Date

Signature certifies attestation of prescription and medical testing evidence provided on this form and represents physician's judgement of the medical necessity for the prescribed equipment and/or treatment as of the date of the signature.